

Respite Care

Definition: Care and Supervision provided to those individuals unable to care for themselves. Services are provided due to the short-term absence or need of relief of those normally providing care. Respite is provided in a variety of settings. FFP will not be claimed for the cost of room and board except when provided as part Respite provided in a facility approved by the State that is not a private residence.

Note: Respite Services and In-Home Supports may not be provided simultaneously.

Note: In-Home Support should also be discussed as an option to Respite when identified needs can be met by either service.

“Hourly respite” can be provided up to twenty-four (24) hours in a calendar day and in a variety of settings such as the individual’s home, a location chosen by the individual/representative, or a licensed respite care facility.

“Institutional respite” is provided in a hospital, nursing facility (NF), an Intermediate Care Facility for the Mentally Retarded (ICF/MR), or SCDDSN Regional Center which has been approved by the State and which is not a private residence.

Note: Respite Services cannot be provided to CSW individuals who reside in a Community Residential Care Facility (CRCF).

Issues regarding payment of respite caregivers for overnight care should be addressed according to individual DSN Board/Respite Provider policy and should be included in the agreement between the DSN Board/Respite Provider and the Respite Caregiver.

Providers: *Hourly respite* can be provided in the individual’s home or place of residence or another residence selected by the individual/representative. This service is provided by people who are hired/contracted by the local DSN Board or Qualified Provider and meet all of the caregiver minimum qualifications.

The respite services provider must meet all provider qualifications and training requirements outlined in SCDDSN’s “Waiver Funded Home Supports, Caregiver Certification” or be a DSN Board employee. Respite services cannot be provided by an individual’s primary caregiver as defined by the State of South Carolina. Family members/relatives of the customer may be paid to provide respite when the family member/relative is not legally responsible for the customer and he/she meets all provider qualifications. Please see Department Directive 735-02-DD entitled “Relatives/Family Members Serving as Paid Providers of Respite Services”.

Determining the amount of respite needed: Respite is a unique service. It can be provided in a variety of setting, in a variety of ways. Often Respite is used in response to a family emergency or crisis. For many individuals, it is used on a regular basis to provide relief to caregivers. For individuals whom Respite is identified as an ongoing service that will be needed on a regular basis, completion of the **Community Support Waiver Respite Assessment (Community Support Form 35)** is required and should be forwarded to the appropriate District Waiver Coordinator when a budget request is made. The **Community Support Waiver Respite Assessment (Community Support Form 35)** is designed to provide you with detailed information regarding the consumer’s difficulty of care, the caregiver’s stress level, and other information related to the need for Respite. The

information gathered from the assessment should help you to determine the amount of Respite appropriate to meet the needs of the individual and their caregiver. This assessment is NOT designed to produce an amount of Respite based on a score. The information included in the **Community Support Waiver Respite Assessment (Community Support Form 35)** should support the amount of Respite requested/provided.

However, if additional units of service are requested exceeding 25 hours per week or 6 days per month, the **Community Support Waiver Respite Assessment (Community Support Form 35)** must be completed and forwarded to the appropriate District Waiver Coordinator when completing the budget request. Furthermore, completion of this assessment is not required for one-time/occasional requests or for Respite uses in response to emergency situations.

Instructions regarding completion of the **Community Support Waiver Respite Assessment (Community Support Form 35)** are included on the form. It is required that the assessment be completed annually with the individual/family. You may already have the information necessary to complete the assessment, but in most circumstances you will have to follow-up with the individual/family for some of the information. Section II of the assessment is to be completed by the caregiver. This portion of the assessment should be given to the caregiver to complete, either by mail, fax, e-mail or in-person. You should not attempt to complete this section with the caregiver. Use this scale when scoring Section II only: Never = 0, Sometimes = 2, Always = 4. The total scores will produce the following categories: 0 - 14 = Mild/No Stress; 15 - 22 = Moderate Stress; and 22 - 36 = Severe Stress.

Arranging for hourly respite: Once it is determined that respite services are needed, the need for the service, the amount needed and the frequency with which the service is to be provided must be clearly documented in the plan.

For *hourly respite*, **one unit = one hour**. When the frequency has been determined, the budget information can be entered in the Waiver Tracking System (S46-Hourly; S13 Institutional).

Each individual must be given a choice of providers of this service and **the offering of choice must be documented.**

Once approved Respite can be authorized using the **Authorization for Services (Community Support Form R-25)** when the following kinds of respite services are chosen:

- hourly respite provided in the individual's home or home chosen by the individual/representative, or
- hourly respite provided in a licensed respite care facility

Issues regarding payment of Respite caregivers for overnight care should be addressed according to individual DSN Board/Respite policy and should be included in the agreement between the DSN Board/Respite provider and the Respite caregiver. For purposes of Waiver budgeting, up to 24 hours of Respite per day can be authorized. However, in most cases when Respite covers a period of 24 hours or more, 8 hours of sleep will be assumed for each night. Therefore, 16 hours per day will be authorized. DSN Boards should ensure that their payment policies adhere to all U.S. Department of Labor and Internal Revenue Service regulations.

Arranging for institutional respite: Once it is determined that institutional respite services are needed or the individual is placed in an ICF/MR, nursing facility, or hospital due to an emergency/crisis, the need for the service, the amount needed and the frequency with which the service is to be provided, must be clearly documented in the plan. **Please note that while an individual is**

receiving institutional respite, they may continue to utilize other Community Support Waiver services (e.g. Assistive Technology). You continue to be the authorizer of all services.

For *institutional respite*, **one unit = one day** when the individual is present in the facility at midnight. When the frequency has been determined, the budget information can be entered in the Waiver Tracking System (S13 Institutional).

Note: The institutional respite rate is very high. Please be careful in monitoring the individual's cost limit.

Each individual must be given a choice of providers of this service and **the offering of choice must be documented.** In the case of an emergency or crisis situation, choice may not be an option. Simply document this in the individual's file.

Once approved, *institutional respite* can be authorized using the **Authorization for Services Community Support Form R-32 (the Services Menu on the STS must also be updated to reflect *institutional respite* as a service that is being received)**. On the authorization indicate where the *institutional respite* will be provided, Center Based Respite (Coastal Center, Midlands Center, Pee Dee Center, Saleeby Center, or Whitten Center), Community Based ICF/MR (noting the name of the facility), Nursing Facility Based, or Hospital Based.

- If the *institutional respite* is to be provided in a SCDDSN Regional Center (Center-Based), the authorization form should be directed to the appropriate Claims and Collections Officer (See Attachment 1 for a list of Claims and Collections Officers). Included with the authorization should be a copy of the individual's Medicaid Card and any other private insurance information.
- If the individual is going to receive *institutional respite* in a community-based ICF/MR, the authorization form should be directed to the board/provider's finance director who operates the community ICF/MR where the individual will receive respite.

For individuals receiving institutional respite at a Regional Center, the Admissions Packet must be submitted to the appropriate Placement Coordinator at the Regional Center (See Attachment 2 for a list of Placement Coordinators). For those receiving institutional respite at a Community ICF/MR, the Admissions Packet must be forwarded to the Board/Provider Residential Director. The admissions packet must include:

- Medication Administration Schedule
- Psychological Evaluation
- Behavior Support Information (if applicable)
- Support Plan
- Nutritional Information
- Physical (completed 30 days prior to respite)
- TB Test (2 step)
- Social History

The individual should bring, at the minimum, the following items when reporting to an ICF/MR, nursing home, or hospital for respite:

- Medications in their original containers
- Spending money
- Medicaid Card

- Clothing
- Toiletries
- Durable Medical Equipment and Supplies (diapers, wipes, etc.)

In cases of an emergency/crisis, some of this information may not be present initially, but should still be obtained and forwarded to the Regional Center Placement Coordinator or the Board/Provider Residential Director.

In order for SCDDSN Central Office to bill for institutional respite, the Service Coordinator must on a monthly basis complete the Individual Service Report (ISR). This form is included for your use. This form should be completed and forwarded to SCDDSN Central Office to the attention of SURB. This must be done no later than the 15th of the proceeding month.

While the individual receives *institutional respite* services, the Service Coordinator is required to monitor the individual's services and progress at the minimum of every two weeks. **If the individual is receiving institutional respite in a SCDDSN Regional Center**, a staffing must be held within 15-30 days of beginning *institutional respite* services. The SCDDSN Regional Center Staff will coordinate this meeting. The Service Coordinator, District Office SCDDSN Staff (if applicable), responsible party/family (if applicable), and Regional Center Staff must be present at the staffing. Discussions will be held in regards to the individual's progress and a decision will be made as to whether or not the individual will continue to receive *institutional respite* (these steps and the staffing are not necessary for someone receiving institutional respite in a community ICF/MR, nursing facility or hospital).

If the team recommends that the individual be admitted to the Regional Center, the following steps must be completed:

- For individuals that reside at home with family (not in a community residential setting), the Service Coordinator must initiate the process for approval of Critical Circumstance (Please refer to SCDDSN Directive 502-05-DD for procedures and forms).

If more restrictive placement/critical circumstance for placement in an ICF/MR is approved, the following steps should be completed:

- The Service Coordinator will notify the Placement Coordinator that the placement has been approved.
- Regional Center staff will complete an ICF/MR Level of Care if the individual has **ever** been admitted to an ICF/MR. If the individual is a new admission, the ICF/MR Level of Care will be completed by the Individual Assessment Team. The Regional Center Staff will be responsible for submitting this packet to the Individual Assessment Team
- Upon notification that the individual has met ICF/MR Level of Care, the Claims and Collections Officer will notify the Service Coordinator and the appropriate Regional Community Support Waiver Coordinator that the individual is ready to be admitted to the Regional Center.
- The Service Coordinator will immediately take steps to ensure that the **Notice of Disenrollment (Community Support Form 17)** is completed within two (2) working days and a **Notice of Termination of Service (Community Support Form 16-B)** will be forwarded to the Claims and Collections Officer to terminate institutional respite services.

The Service Coordinator will remove Institutional Respite as a service being received from the services menu on the STS so that ISR reports are no longer generated.

- The Claims and Collections Officer/Person Completing DHHS Form 181 will check the Waiver Tracking System to ensure that the individual has been disenrolled from the Community Support Waiver before proceeding with admitting the individual to the ICF/MR and completing the DHHS Form 181 Form. A copy of the DHHS Form 181 form will be forwarded to the Waiver Enrollments Coordinator. If the Claims and Collections Officer notes that the individual continues to remain enrolled in the Community Support Waiver, they will notify the appropriate Regional Community Support Waiver Coordinator.

If the team recommends that the individual continue to receive SCDDSN Regional Center *institutional respite*, the following steps must be taken:

- Another staffing must be held within 15-30 days of the initial staffing. The SCDDSN Regional Center Staff will coordinate this second meeting. The Service Coordinator, District Office SCDDSN Staff (if applicable), responsible party/family (if applicable), and Regional Center Staff **must** be present at the staffing. Discussions will be held again in regards to the individual's progress and a decision will be made as to whether or not the individual will continue to receive *institutional respite* or if the team recommends admission to an ICF/MR.
- If the outcome of the meeting indicates that the individual will continue to receive *institutional respite*, the Service Coordinator is responsible for notifying Central Office of this decision. This may be done via e-mail. If there are any issues or concerns, the Service Coordinator will be notified. A new **Authorization for Services (Community Support Form R-32)** must be completed and forwarded to the Claims and Collections Officer and SCDDSN Central Office attention SURB Respite Care Authorizations. **Be mindful that the CSW has a cap and therefore it is imperative that you carefully monitor the situation to avoid exceeding the funding cap and to determine if transfer to the ID/RD waiver is needed.**

If the team recommends that the individual be admitted to an ICF/MR, the procedures outlined above must be followed.

Given the circumstances surrounding the need for institutional respite, multiple staffings may be held with the outcome being that institutional respite services continue for an extended period of time. The above steps must be followed and a staffing must be held at least each month. SCDDSN Central Office must be notified as outlined above.

Please note: Although a staffing must be held at the minimum of every 15-30 days, up to 45 units of institutional respite can be and should be authorized. This will allow for any lapse that may occur. If the Regional Center does not have an authorization form they cannot bill for this service. If an individual is admitted during a crisis on the weekend or in the evening, service may be authorized verbally and the **Authorization for Services (Community Support Form R-32)** completed on the next business day. The form should be completed by the person that gave verbal approval for institutional respite. In this case they may authorize that the service began on the date that verbal approval was given and they may sign the form on the same date. This authorization should come from the Service Coordinator, Service Coordination Supervisor, Upper DSN Board management, or the Executive Director. All of this should be carefully documented in the individual's file to include the verbal authorization.

Monitoring the Services: You must monitor the effectiveness, frequency, duration, benefits, and usefulness of the service along with the individual's/family's satisfaction with the service. Information gathered during monitoring may lead to a change in the service, such as an increase/decrease in units authorized, change of provider, change to a more appropriate service, etc. The following criteria should be followed when monitoring Respite Services.

Respite (hourly)

- At least once each month for the first two months
- At least every six (6) months thereafter

Respite (institutional)

- Every two weeks for the first month
- At least monthly thereafter

It may also be monitored during a review of notes completed during a respite stay. Monitorship of the individual's health status should always be completed as a part of respite monitorship.

Some items to consider during monitorship include:

- Is the individual receiving respite care as authorized?
- Is the individual satisfied with the current respite provider?
- Does he/she show up on time and stay the scheduled amount of time?
- Does the provider show the individual courtesy and respect?
- Does the caregiver feel that he/she is receiving enough relief from providing for the individual's care?
- Does the service need to be continued at the current rate?
- Is there need for additional respite to be requested at this time?
- Are they pleased with the care being provided by the respite caregiver or is assistance needed in obtaining a new caregiver?

Reduction, Suspension, or Termination of Services: If services are to be reduced, suspended, or terminated, a written notice must be forwarded to the individual or his/her legal guardian including the details regarding the change(s) in service, allowance for appeal/reconsideration, and a ten (10) calendar day waiting period before proceeding with the reduction, suspension, or termination of the waiver service(s). The general termination form that has been used in the past for all waiver services is no longer used. See **Chapter 8** for specific details and procedures regarding written notification and the appeals process.

**South Carolina Department of Disabilities and Special Needs Regional Center
Claims and Collections Officers**

Midlands Center

Midlands Center
8301 Farrow Road
Columbia, SC 29203-3294
(803) 935-7364
fax: (803) 935-6177

Whitten Center

Whitten Center
P.O. Box 239
Clinton, SC 29325
(864) 938-3165
fax: (864) 938-3115

Coastal Center

Coastal Center
9995 Jamison Road
Summerville, SC 29485
(843) 821-5810
fax: (843) 821-5889

Pee Dee and Saleeby Center

Pee Dee Center
714 National Cemetery Road
Florence, SC 29502-3209
(843) 664-2613
fax: (843) 664-2692

**South Carolina Department of Disabilities and Special Needs Regional Center
Placement Coordinators**

Midlands Center

Midlands Center
8301 Farrow Road
Columbia, SC 29203-3294
(803) 935-6037
fax: (803) 935-7678

Whitten Center

Whitten Center
P.O. Box 239
Clinton, SC 29325
(864) 938-3396
fax: (864) 938-3115

Coastal Center

Coastal Center
9995 Jamison Road
Summerville, SC 29485
(843) 821-5854
fax: (843) 821-5800

Pee Dee and Saleeby Center

Pee Dee Center
P.O. Box 3029
Florence, SC 29501
(843) 664-2635
fax: (843) 664-2692

South Carolina Department of Disabilities and Special Needs

Statement of Legal Responsibility for Respite Services

Individual's Name: _____

SSN: _____

Date of Birth: _____

Respite services are defined as care provided to the SCDDSN individual in the absence of the caregiver or when the caregiver needs relief from the responsibilities of care giving. An individual's primary caregiver(s) cannot provide respite. The primary caregiver(s) of the individual noted above is/are:

South Carolina Medicaid Policy prohibits anyone who is legally responsible for the health care decisions of another to be paid for rendering respite services to that person. If you are legally responsible for the health care decisions of the individual noted above you can not be paid for providing respite services.

By signing this statement you acknowledge that:

- you are not a primary caregiver of the individual noted above, AND
- you are not legally responsible for his/her health care decisions.

I am not a primary caregiver of the person noted above and I am not legally responsible for the person noted above.

Signature

Date

Printed Name

**S. C. DEPARTMENT OF DISABILITIES AND SPECIAL NEEDS
COMMUNITY SUPPORT WAIVER**

**AUTHORIZATION FOR SERVICES
TO BE BILLED TO DSN BOARD**

TO: _____

RE: _____

Individual's Name

/

Date of Birth

Address

Medicaid #

/ / / / / / / / / / / /

You are hereby authorized to provide the following service(s) to the person named above. Only the number of units rendered may be billed. Please note: This nullifies any previous authorization to this provider for this service(s).

Respite Care Services:

Hourly Respite

Number of Units Per _____ :

(one unit = 1 hour of service)

REMIT BILL TO (Please print):

Signature of Person Authorizing Services

Date

Board Name/Address _____

**S. C. DEPARTMENT OF DISABILITIES AND SPECIAL NEEDS
COMMUNITY SUPPORT WAIVER**

**AUTHORIZATION FOR ICF/MR (INSTITUTIONAL) RESPITE SERVICES
TO BE BILLED TO DSN BOARD**

Center-Based Respite

- ☐ Coastal Center
- ☐ Midlands Center
- ☐ Pee Dee Center
- ☐ Saleeby Center
- ☐ Whitten Center

☐ **Community ICF/MR**

Name of facility

☐ **Nursing Facility**

☐ **Hospital**

TO: _____

For Center Based: Claims and Collections (see attachment)

For Community ICF/MR: Board/Provider Finance Director

Address

RE: _____

Individual's Name

/

Date of Birth

Medicaid # / / / / / / / / / / / /

Social Security # / / / / / / / / / / / /

You are hereby authorized to provide institutional respite to the individual named above. The individual cannot be admitted to the ICF/MR (DHHS 181 completed) without first notifying the Service Coordinator (noted below) and verifying that the individual has been disenrolled from the Community Supports Waiver. Please note: This nullifies any previous authorization to this provider for this service.

Institutional Respite

☐ Number of Units _____ (one unit = number of nights spent in the ICF/MR)

Start Date: _____

Service Coordinator/Early Interventionist _____

Board/Provider: _____

Address: _____

Phone Number (with extension when appropriate): _____

Signature of Person Authorizing Services

Date

SOUTH CAROLINA DEPARTMENT OF DISABILITIES AND SPECIAL NEEDS
Home and Community Based Waiver
Respite Care – Regular
Individual Service Report

For: _____ (month and year)

Region: _____ Provider Name: _____

Paid Number: _____ Provider No: _____

Individual SSN: _____ - _____ - _____ Individual Name: _____

Medicaid #: _____

Service Coordinator's Name: _____

Service Coordinator's Signature: _____

Type Of Service: Respite Care (_____) Each service reported must be documented in Individual's File					
Non-Facility Based Hourly Respite <i>(Fill in the date of service, the beginning and ending time for all non-facility based respite)</i>				Facility Based Daily Respite <i>(Fill in the date of service)</i>	
Date of Service	Beginning Time (Hours/Minutes)	Ending Time (Hours/Minutes)	DDSN Use	Date of Service	DDSN Use
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Comments _____ _____ _____ _____				Comments: _____ _____ _____ _____	

Attn: Comments are required if no activity is rendered.

SC Department of Disabilities & Special Needs
Home Supports
Caregiver Certification

Effective February 2008

The following guidelines apply to Individual Rehabilitation Supports, MR/RD Waiver and HASCI Waiver funded home supports that are provided by DSN Boards. These guidelines supersede portions of DDSN Administrative Agency Standard relating to Staff Development and Training (136), and all other policies, directives, or guidelines regarding the provision of designated services through a DDSN Home and Community Based Waiver or Rehabilitation Supports. All payments must be made directly to the provider of the service (caregiver) and cannot be made to the family or the recipient. Payments will not be made for services rendered by relatives of the recipient as defined by South Carolina Medicaid Home and Community Based Waiver policy. Services covered in these guidelines are:

MR/RD Waiver:	Respite, Companion, and Homemaker
HASCI Waiver:	Respite, Personal Assistance/Attendant
CS Waiver:	Respite, In-Home Support
PDD Waiver:	Respite, Companion, and Homemaker

Minimum qualifications for caregivers:

- ☐ The caregiver will have the ability to read, write and speak English.
- ☐ The caregiver will be at least 18 years of age.
- ☐ The caregiver will be capable of aiding in the activities of daily living (not required for Rehabilitation Supports caregiver if not part of the job for which he/she is hired).
- ☐ The caregiver will be capable of following a plan of service with minimal supervision.
- ☐ The caregiver will have no record of abuse, neglect, crimes committed against other people or felonious convictions of any kind.
- ☐ The caregiver will be free from communicable and contagious diseases.
- ☐ The caregiver must maintain a valid Driver's License and be insurable (if driving is required as part of the job).
- ☐ The caregiver will document hours worked and the nature of the tasks performed. The waiver recipient or his/her designee (i.e., parent, sibling, etc.) will verify the documentation.
- ☐ If providing Personal Assistance/Attendant Care supervision will be provided by a RN or as otherwise allowed within the provision of state law.
- ☐ The caregiver will demonstrate competency in required training. (See attached training requirements for caregivers.) Training will include the attached minimum guidelines for training as well as any special techniques/procedures/equipment required to adequately provide services for the individual prior to assuming responsibility.



Training Requirements for Caregivers

All caregivers must have the skills and abilities to provide quality services for the people they serve. Minimally, caregivers must demonstrate competency in the following areas (taken directly from the person-specific service curriculum) before services are provided. *Hours in parentheses are estimates of the time needed to achieve competency and may be higher or lower depending on the existing skill level of the caregiver and the skills required for serving a particular waiver recipient.*

1. Confidentiality, Accountability and Prevention of Abuse and Neglect (1.5 hours)
2. First Aid (4 hours)
3. Fire Safety/Disaster Preparedness related to the specific location of services (1 hour)
4. Understanding Disabilities (MR/RD and Autism)

OR

Orientation to Head and Spinal Cord Injuries (HASCI): This training must be specifically related to the person/family needing services (1-3 hours)

5. Signs and Symptoms of Illness and Seizures (1 hour)

The following describes two ways in which caregivers can demonstrate competency:

1. Taking and passing tests (curriculum) in the above categories. Tests may be taken as part of DSN Board training or may be taken when training does not occur.
2. Recipient/responsible party can approve caregiver competency for items 3 - 5 above, but cannot sign off on items 1 or 2.

Caregivers must also demonstrate competency in any person-specific special techniques / procedures / equipment and must be oriented to the habits, preferences, and interests of the person. Caregivers must be able to communicate with the recipient. The recipient or family will typically provide this training to the caregiver. DSN providers, however, should allow access, upon request, to training classes and/or assist with caregiver training. The recipient/responsible party, prior to services beginning, must complete the attached Caregiver Certification form for each caregiver. This form along with supporting documentation (training records, tests, etc.) will be maintained by the local DSN Board.

HOME SUPPORTS CAREGIVER CERTIFICATION

Caregiver Information:

Name:	_____
Social Security Number:	_____
Address:	_____ _____
Phone Number:	_____

The above named caregiver has demonstrated competency in the areas noted below through the successful completion of training or by exemption from the training as approved by me.

Name of Training	Training/Date	Exemption/Date
Confidentiality, Accountability & Prevention of Abuse and Neglect		XXXXXXXXXXXXXXXXXX
First Aid		XXXXXXXXXXXXXXXXXX
Fire Safety/Disaster Preparedness		
Understanding Disabilities (MR/RD or Autism) OR Orientation to Head and Spinal Cord Injuries		
Signs and Symptoms of Illness & Seizures		

The above named caregiver has been oriented to the habits, preferences and interests of _____ and is competent to perform the tasks needed to provide his/her care.

Individual/Responsible Party

Date

Relationship of Responsible Party to Individual